Rhode Island Executive Office of Health and Human Services
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October 17, 2016

Docket # 16-2702
Hearing Date: October 5, 2016

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided **partially** in your favor in that you can re-enroll at this time, but you are **no longer eligible** for tax credits. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE (RIHBE)

SECTION 7.0 Termination of Coverage and Grace Periods-
Sections 7.1; 7.2; 7.5; 7.8

HEALTHSOURCE RHODE ISLAND POLICIES & PROCEDURES
CHAPTER XII. Billing and Late Payments-A. Termination of Coverage in the Individual market; B. Notification; C. Effective Dates of Termination of Coverage; L. Notification

The facts of your case, the Agency regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the Appellant), and Health Source RI (HSRI) Agency representatives: Lindsay Lang Esq., and Ben Gagliardi Esq., and Derek Tevyaw.

Present at the hearing were: You (the Appellant), and HSRI representative Ben Gagliardi.

ISSUE:
Should the appellant's medical coverage have terminated as of July 31, 2016?

RIHBE RULES AND REGULATIONS:

Please see the attached APPENDIX for pertinent excerpts from the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Health Source Rhode Island (HSRI) representative testified:

- The September 3 Dis-enrollment notice said the coverage terminated on July 31st.
- This was a termination for non-payment.
- Health Source received two payments in 2016 from her (the appellant), one on March 1st ($9.31), and the other on March 14th, in the amount of $1.66.
- She was enrolled in a Blue Cross/Blue Shield plan.
- On July 1st her plan rate changed due to losing eligibility for tax credits because HSRI had received information that external date sources showed her to be eligible for Medicare.
- We have here the last verification from external data sources, an August 10th screenshot in which we are still being told that she (the appellant) is entitled to Medicare.
- At that point tax credits were removed effective July 1st, and payment was not received by July 31st, then coverage was terminated on July 31st.
- July was the first grace period month in which payment was not received in full for that month, and coverage ended at the end of that month.
- The one month grace period applies in this case because when tax credits are removed, an individual is eligible for only a one month grace period versus the three month grace period for individuals receiving tax credits.
- So, coverage ended on July 31st.
- We have a copy of the September 3, 2016 dis-enrollment notice sent to her and showing a termination date of July 31st for no payment received.

- The Intent to Terminate notice would have gone out prior to termination requesting payment for the past due balance.

- We've requested the Intent to terminate notices and we will request the 2016 Enrollment notices.

- We agree that during the 90 day period if she showed she did not have access to Medicare she could have had the tax credits removed retroactively, but HSRI never received the documentation, and so they removed the tax credits which resulted in non-payment.

- We feel that the 90 day notice is not relevant to this appeal which is a termination for non-payment but we will pull the notice and submit it during the held open.

- We do not know the date of that actual notice.

- Payment was not received in July, and according to our regulations we correctly terminated at the end of July.

- She was not dis-enrolled until the end of July and the 90 day period to provide the documentation

The appellant testified:

- She was told by the pharmacy and by the physician's office on July 12 when she went to fill a prescription that she no longer had coverage.

- She called Health Source throughout the month of July, and was told continually that they did not get paperwork saying she was not eligible for Medicaid and was told they would expedite her issue.

- On the website in July she explained that she was not eligible for Medicaid in the area that allowed an explanation and stated she does not have documentation saying she does not have Medicaid.

- She understood through HSRI there was a state law saying she had 90 days to provide documentation, and she was trying to provide what they were requesting from the date she received the request.

- Between July 1st and September she was told she could still have retroactive re-enrollment in the old plan if she had the documents.

- She continued to talk to HSRI and they said they would expedite which would take about 30 days, and around the 30 day mark she was told that she did not comply with the recommendation to provide documentation about MEDICAID, and so the decision to terminate her Health Source would stand.

- She was told she could appeal at that time which she did.

- Health Source had never received her first appeal, and so someone on the phone expedited her second request for an appeal.

- Between July 1st and September she was told she could be retroactively re-enrolled to pay the $9.00 not the new $578, and that had been the ongoing discussion.

- In September she told them she could not pay $578 per month, and she was told that was the only way she could re-enroll at this time.

- She appealed on September 6th, because she received the termination notice after the fact and she had never been aware that it was for non-payment that she was being terminated for that reason.

- She understood that termination was related to a lack of documentation.

- She understood she had 90 days to provide documentation from the date she received the request.

- She did not re-enroll in the new priced plan right before she came to appeal because she knew she could not afford the new price.

- She did get a notice which she believed said she needed to prove she did not have access to Medicaid, and it could have said Medicare

- When she went to re-enroll in December 2015 and she was asked about Medicaid at that time.

- She wondered why are they would ask for documentation that said I don't have Medicaid?

- Yes, if she had been clear in her mind they were looking for Medicare not Medicaid, she would have provided the documents.

FINDINGS OF FACT:

- A January 19, 2016 "Additional Documentation Required" notice informs the appellant that documents with information about her access to public coverage are due by February 2, 2016.

- A full payment history shows two 2016 payments-$9.31 on March 1st, and $1.66 on March 14th.

- A May 29, 2016 notification identifies that the documents about access to public coverage must be received by June 29, 2016. “Failure to provide documentation will result in your tax credits being taken away…”If Health Source RI does not receive information from you as of June 29, 2015 your financial assistance will be removed effective July 1, 2016.”

- August 20 and August 21 notices indicate the new cost of $577.60 for continued coverage in the Blue Cross Health which had previously cost $1.66-with an effective starting date of July 1st.

- A September 3, 2016 Dis-enrollment notice identifies the loss of coverage effective July 31st resulting from “No payment received.”

- Medicare documents were submitted post hearing-October 7, 2016.

- The appellant appealed on September 6, 2016.

- A hearing was convened on October 5, 2016.

- The record of hearing was held open to October 12th for submission of additional evidence.

- Both parties submitted additional information.

CONCLUSION:

Should the appellant’s medical coverage have been terminated as of July 30, 2016?

There is no dispute that the appellant received a September 3, 2016 notification that indicated her loss of coverage as of July 31st for reason-No payment received. The appellant states that she is actually appealing the lack of notifications about changes to her insurance which resulted in a July 1st discontinuance of her tax credits. As the result of the loss of tax credits, her insurance increased to $576 for the same policy, a cost which she did not pay and believes she is unable to pay.

A review of Rhode Island Health Benefits Exchange regulations identifies that individuals receiving advance premium tax credits shall be provided “a grace period” of three consecutive months if the enrollee has paid at least one full month’s premium during the benefit year; and, one month if the enrollee does not receive credits. Additionally, regulations require at least a 30 day notification prior to termination.

The appellant argues that during the month of July she became aware of the hike in her premium resulting from her omission to send in documents stating she was not eligible for Medicare. She states that she understood she could submit documents any time up to September, but that the information obtained from the Health Source representatives in July precluded her from sending the corrected information, as they continually used the word-Medicaid instead of Medicare. She had difficulty establishing that she did not have Medicaid. She testified to going on line in July and attempting to inform the system she did not have Medicaid which she did not. She testified she could not afford the jump in the premium on July 1st without tax credits. She believes she should have access to tax credits because she does not yet have access to Medicare insurance benefits, and that her account should not have been closed for non-payment.

The Agency presented that the appellant was arguing her loss of tax credits, which occurred on July 1st, an issue which is no longer timely, and for which she had notification. Further, they argue that the appellant was dis-enrolled for lack of payment in full for the month of July, not for failure to provide documents. The Agency noted that their system had indicated the appellant had become eligible for Medicare coverage, and thus, ineligible for continued tax credits. They further argue that upon losing her tax credits, the appellant also lost the opportunity for an extended 90 day grace period. After missing her first months' July payment at the new rate, the appellant's coverage then closed on July 30th, the end date for the one month grace period afforded non-tax credit accounts.

Review of the testimony and evidence submitted during and post hearing reveals that the appellant was first notified during enrollment notifications in January 2016 that she needed to provide information about her access to public coverage. Four months later the appellant was notified again through the May 29th notice that information about access to public coverage was being requested. It read in part, "In most cases, when someone becomes eligible for…Medicare …they are no longer eligible to receive Advance Premium Tax Credits..." It further notified that failure to provide the documents by June 29th would result in removal of tax credits on July 1st. The appellant argues that her conversations in July prevented her from producing the correct documents. However, by July 1st the appellant had correctly, per regulations, and per prior notifications both in the January and May notices-already lost the coverage with tax credits thus increasing the cost of her premium considerably. The appellant had also been notified in January and in May that the documents needed were Medicare related. She testified that she may not have fully read the notice as her mind when making initial application was centered on the Medicaid issue, not the Medicare issue.

The appellant believed prior to hearing that she had lost her coverage due to omission to provide documents. She was unaware she had lost coverage due to non-payment as noted in the September 3rd notice, post closure. She argued that she was never made aware of the closure through notifications. As discussed earlier, the appellant, after proper notification, lost her tax credits on July 1st. Due to the loss of tax credits, regulations require only a 30 day grace period for non-tax credit recipients, in which to pay their bill. The appellant argues no notification of termination notices which would

have informed her of imminent closure. The Agency argued that they had sent termination notifications to the appellant and would provide such notification post hearing. Post hearing, the Agency did not establish that they had ever notified the appellant of imminent closure through notices. The appellant had a right to such notification, allowing her to remain in the plan, but at full price. It is unclear if the appellant would have chosen to remain in the plan at full price.

In summary, the appellant argues that she was informed after the fact, and without proper notice, that she had had her health insurance terminated. She believed the termination resulted from her lack of submission of documents as they related to her Medicare. The reason for termination was due to her failure to pay her July premium in full. The record establishes that the appellant was correctly notified in January 2016, and again in May 2016 that failure to provide documents which proved that she had no access to Medicare would result in loss of her tax credits on July 1st. She did not submit any documents and on July 1, upon losing her tax credits, her premium rate increased $576.00. When she did not pay the premium in full, closure took place at the end of July. As a non-tax recipient the appellant was allowed only a 30 day grace period before closure. However, the Agency did not give prior notification of termination. Regulations allow closure after a 30 day grace period has been exhausted for non-tax recipient enrollees. Thus, because the appellant was not properly notified of termination, she is eligible to have her benefits reinstated retroactively to July 1st, or beginning November 1st. However, the appellant is responsible for the full cost of the plan without tax credits.

Let it be noted, that the appellant indicated she was not eligible for Medicare insurance benefits at this time. She submitted, post hearing, a copy of her SSA Notice of Award. Although she testified she was unable to obtain Medicare medical insurance at the time, a review of the letter suggests the appellant may choose to explore more fully her Medicare options, as she may be currently eligible to obtain the Medicare due to the onset date of her disability benefits in August 2013.

Thus, after a careful review of the Agency's regulations and policies; and the testimony and evidence submitted, this Appeals Officer finds that the appellant's request for relief is **partially** granted. If she chooses she may continue coverage through HSRI either retroactively to July 1st or prospectively beginning November 1st. The appellant is no longer eligible for tax credits at this time.

ACTION FOR THE AGENCY:

The Agency is to allow the appellant retroactive coverage beginning on July 1, 2016, or to allow coverage beginning on November 1, 2016. The appellant is no longer eligible to receive tax credits.

Karen Walsh
Appeals Office

APPENDIX

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

SECTION 7.0 TERMINATION OF COVERAGE AND GRACE PERIODS

7.1 **In General.** Section 1412(c)(2) of the ACA, and its implementing regulation, 45 C.F.R. §156.270, establishes a three-month grace period for non-payment of premium before coverage will be terminated for a qualified individual who is receiving advance payment of premium tax credits and has made at least one full month's premium payment during the benefit year. 45 C.F.R §155.430 establishes procedures for termination of QHP coverage.

7.2 **Termination of Coverage Due to Non-Payment of Premium.** The Exchange shall establish a standard policy for the termination of coverage of enrollees due to non-payment of premiums. This policy for the termination of coverage:
(a)) Must include the grace period for enrollees receiving advance payments of the premium tax credits; and
(b) Must be applied uniformly to enrollees in similar circumstances.

7.5 **Involuntary Termination.** The Exchange may promptly initiate termination upon any of the following events:
(a) The enrollee is no longer a qualified individual as determined based on information submitted by the enrollee or information obtained by the Exchange.
(b) The enrollee dies.
(c) Non-payment of premiums, after the exhaustion of any applicable grace period pursuant to §§ 7.3(a) and (b) of these Regulations.
(d) The QHP terminates or has been decertified, which constitutes a loss of Minimum Essential Coverage. The qualified enrollee will be given an opportunity to enroll in a new QHP pursuant to special enrollment periods set forth in §4.6(a) of these Regulations.
(e) The qualified individual selects a different QHP during an open or special enrollment period.

7.8 **Effective Date of Termination.**
(a) *Voluntary terminations*.
(1) Upon a voluntary termination request submitted at least fourteen (14) days prior to the end of the month, coverage shall be terminated at the end of the month. Coverage shall be terminated at the end of the following month if the termination request is submitted less than fourteen days prior to the end of the month.
(2) The Exchange may grant a different termination date if the request is submitted at least fourteen (14) days prior to the proposed termination date.
(3) The Exchange has discretion to grant an earlier termination date, on a case-by-case basis.
(4) If the enrollee requests coverage termination due to eligibility for Medicaid, coverage will terminate the day before Medicaid coverage begins.
(b) *Involuntary terminations.*
(1) If the enrollee is no longer a qualified individual as determined upon receipt of

information from the enrollee or information obtained by the Exchange, coverage will terminate on the last day of the month following the month in which the Exchange sent the enrollee notice of an eligibility redetermination. In such a case, the enrollee may request an earlier termination date, pursuant to §7.8(a) of these Regulations.
(2) If the coverage is terminated for non-payment pursuant to §7.5(c) of these Regulations.
(3) If the enrollee dies, coverage terminates on the day of the death. Premiums will be refunded by the Exchange to the estate for the remainder of the month.
(4) If the enrollee changes Qualified Health Plans, the existing Qualified Health Plan coverage terminates the day before the new coverage begins.
(5) If the Qualified Health Plan terminates or is decertified, coverage will terminate the day the Qualified Health Plan terminates or is decertified, unless the enrollee is granted an earlier termination date pursuant to §7.8(a) of these Regulations.

CHAPTER XII. BILLING AND LATE PAYMENTS

A. Termination of Coverage in the individual market

Issuers of QHPs may not terminate the coverage of any QHP enrollees for any reason.[1, 2] Should an issuer believe that termination of an enrollee is warranted, the issuer may request that termination be initiated by HealthSource RI by providing notice to HealthSource RI in writing or in such other format as HealthSource RI may determine. Upon examination and successful validation of such request, HealthSource RI will initiate such termination and provide notice of termination to the enrollee and the Issuer.

Involuntary Termination: HealthSource RI will initiate the termination of an enrollee's coverage in the following circumstances[3]:

- The enrollee is no longer eligible for coverage through HealthSource RI;
- Non-payment of premiums, after the exhaustion of any applicable grace periods;
- The enrollee's coverage has been terminated;
- The QHP terminates or is decertified;
- The enrollee changes from one QHP to another during a qualified enrollment period

Voluntary Termination: HealthSource RI will allow an enrollee to terminate his or her coverage in a QHP at any time, including as a result of the enrollee obtaining other minimum essential coverage.[4] An enrollee may terminate his or her coverage through U.S. mail, fax, calling or visiting the HealthSource RI contact center in person.

The effective dates of terminations are described in Section C below.

Example: Consider an enrollee who moves out of the state of Rhode Island, and is no longer eligible for coverage through the QHP, HealthSource RI will terminate such enrollee's coverage.

Example: Consider an enrollee who fails to pay their required premium and has exhausted their applicable grace period, HealthSource RI will terminate such enrollee's coverage.

B. Notification

Upon involuntary termination, HealthSource RI shall provide the Enrollee with a notice of termination as well as any other additional notices, as appropriate. This notice will include the reason for termination and will be sent at least 30 days prior to the last day of coverage.[5] The issuer shall provide other notices upon termination, such as the certificate of creditable coverage, as appropriate.

[1] 45 CFR 155.430(a)
[2] 45 CFR 156.270(a)
[3] 45 CFR 155.430(b)(2)
[4] 45 CFR 155.430(b)(1)
[5] 45 CFR 156.270 (b)(1)

Termination notices are always sent by mail, regardless of whether the individual has set his or her notification preference to email. The termination notice will be sent to the primary account contact. If the individual has authorized a representative to make decisions on that individual's account, and the authorized representative's address is listed on the account, then the authorized representative is considered the primary account contact and will receive the termination notice.

C. Effective dates for termination of coverage

In the case of a termination where the enrollee wishes to terminate his or her coverage in a QHP, the last day of coverage will be[6]:

- The last day of the month during which termination is requested by the enrollee, so long as termination is requested at least fourteen days before the end of the month; otherwise the last day of the following month; or
- If the enrollee requests a different termination date, than on the termination date specified by the enrollee, so long as reasonable notice (14 days) has been provided; or
- If the enrollee requests a termination with less than 14 days notice, HealthSource RI may in its discretion allow termination effective as of the date requested; or
- If the enrollee is terminating due to new eligibility for Medicaid, the last day of QHP coverage is the day before the individual is determined eligible for Medicaid; or
- If enrollee is terminated because of switching from one QHP to another during open enrollment or special enrollment, the last day of coverage in an enrollee's previous QHP is the day before the effective date of coverage in his or her new QHP, including any retroactive enrollments

In the case of a termination due to the individual becoming ineligible for coverage in a QHP through HealthSource RI, the last day of coverage will be the last day of the month following the month that HealthSource RI sent notification of an eligibility redetermination.[7] The individual may also request an earlier termination date.[8]

In the case of termination due to the death of an enrollee, the last date of coverage shall be the day of the death.[9] For mid-month terminations due to deaths, premiums shall be prorated in accordance with a 30-day prorating rule. The premium payable for that terminated enrollee shall be calculated as follows:

(Total Days of Coverage Received / 30) x Full Monthly Premium

Example: Consider an enrollee who was paying $240 per month for his premium. If such enrollee were to die on July 20th, their coverage would be terminated on July 20th and their premium would be prorated using the calculation as follows:

(20/30) x $240= $160

The premium payable for that terminated enrollee would equal $160.

In the case of a termination due to non-payment of monthly premium:[10]

- If the individual receives APTCs and, as a result, is eligible to receive a 3-month grace period, the last day of coverage will be the last day of the first month of the 3-month grace period.
- For individuals not receiving APTCs, the last day of coverage will be the last day of the 1-month grace period.

[6] 45 CFR 155.430(d)(1)-(2)

[7] 45 CFR 155.430 (d)(3)

[8] 45 CFR 155.430 (d)(3)

[9] 45 CFR S. 155.430(d)(7)

[10] 45 CFR 155.430 (d) (4)-(5)

Example: Consider an enrollee is eligible for APTCs and who fails to make a premium payment for May coverage by the April 23 deadline. The individual has until July 23 to pay the outstanding balance on the account. If no payment is received by July 23, that individual is terminated from his or her plan effective May 30.

Example: Consider an enrollee who is not eligible for APTCs and who fails to make a premium payment for May coverage by the April 23 deadline. The individual has until May 23 to pay the outstanding balance on the account. If no payment is received by May 23, the individual is terminated from his or her plan effective May 30.

For all other cases of involuntary termination, HealthSource RI shall set the effective date of termination in accordance with applicable law.[11]

Example: Consider an enrollee who wishes to voluntarily terminate his or her coverage on the 30th of the month; notification of such termination would have to be received by HealthSource RI on or before the 16th of that month in order to be effectuated by HealthSource RI.

Example: Consider an enrollee who wishes to voluntarily terminate his or her coverage, and submits their request to HealthSource RI on May 10th but does not specify a requested termination date. The effective date of termination will be May 31st.

Example: Consider an enrollee who has become eligible for Medicaid with a coverage effective date of April 1st. Existing coverage will be terminated by HealthSource RI on March 31st.

Example: Consider an enrollee who is re-determined by HealthSource RI to be ineligible for coverage through a QHP, and is notified of such redetermination on September 18th. Barring a request to provide additional documentation in support of eligibility, the last day of coverage for such individual will be September 30th.

Example: Consider an enrollee who is enrolled in a QHP that has been decertified, and can no longer participate on HealthSource RI, HealthSource RI will terminate such enrollee's coverage. The effective date of the termination will be the last day of the month at which point the QHP will no longer offer coverage. Enrollees will receive notification of a 60 day time period (a special enrollment period) within which they are able to select a new QHP.

Example: Consider a non-APTC eligible individual enrollee who has not paid their premium for March coverage, which was due on the 23rd of February. A late payment notice will be generated on the 26th of February and sent to the enrollee. Such notice will include the amount due and the date that coverage will be terminated if payment is not received.

Example: Consider an individual who is a non-APTC recipient enrollee and has failed to pay their required premium for April coverage that was due on March 23rd. A late payment notice would be sent on the 26th of March. Their 1-month grace period will extend from April 1st through April 30th. The last day of coverage for this individual will be April 30th.

For APTC recipients, invoices, late & termination notices will be sent during the delinquency process as follows:

- On the 26th day of the first month of late-payment a notice indicating the non-payment of premium and the time remaining in the grace period will be included as a message text within the monthly invoice.
- On the 26th day of the 2nd month of non-payment, a notice of non-payment containing information regarding the grace period will be included with the monthly invoice.
- On the 26th day of the 3rd month of non-payment, an invoice will be sent including a message that coverage will terminate as of the last day of that month due to non-payment.
- On the 1st day of the 4th month, a notice will be sent advising the enrollee that their coverage has been terminated due to non-payment.

Example: Consider an APTC individual who has not paid any of their previous month's payments in full during the 3-month grace period. Payment was due on February 23rd for the March coverage month. The 3-month grace period started March 1st. The notifications this individual received will be as follows:

- On February 26th, the ongoing monthly invoice run for the individual included a late payment message and advises the consumer that the 3-month grace period is in effect. The invoice includes current amount due for April and past due amount for March.
- On March 26th, a notice indicating the non-payment is sent separately from the monthly invoice and message text regarding the grace period is listed on the ongoing monthly invoice generated on March 25th. The ongoing monthly invoice includes the current amount due for May and past due amount for March and April.
- On April 26th a notice indicating the non-payment and the intent to terminate is sent as a stand-alone letter. The ongoing monthly invoice is also sent and includes current amount due for June and past due amount for March, April and May.
- On June 1st, the individual's account is terminated for nonpayment back to the March 31st effective termination date, and a termination letter is sent to the individual. No further invoices are mailed to the individual.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

This hearing decision constitutes a final order pursuant to RI General Laws §42-35-12. An appellant may seek judicial review to the extent it is available by law. 45 CFR 155.520 grants appellants who disagree with the decision of a State Exchange appeals entity, the ability to appeal to the U.S. Department of Health And Human Services (HHS) appeals entity within thirty (30) days of the mailing date of this decision. The act of filing an appeal with HHS does not prevent or delay the enforcement of this final order.

You can file an appeal with HHS at https://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf or by calling 1-800-318-2596.